

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0044024</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>SAINT CLARE HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2002</u> to <u>09/30/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>5533 N. GALENA ROAD</u> <u>Mattoon</u> <u>61938</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Peoria</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Carolyn Conover</u> (Title) <u>Administrator</u>	
<b>Telephone Number:</b> <u>(309) 682-5428</u> <b>Fax #</b> ( ) _____		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Craig L. Ater</u> (Firm Name & Address) <u>Heritage Enterprises</u> (Telephone) <u>(309) 823-7135</u> <b>Fax #</b> ( ) _____	
<b>IDPA ID Number:</b> <u>370813229001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>09/01/98</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>CRAIG L. ATER</u> <b>Telephone Number:</b> ( ) _____			

Facility Name & ID Number SAINT CLARE HOME# 0044024 Report Period Beginning: 10/01/2002 Ending: 09/30/2003**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,410</u>	3
4		Intermediate/DD			4
5	<u>4</u>	Sheltered Care (SC)	<u>4</u>	<u>1,460</u>	5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,985</u>	<u>10,682</u>	<u>3,000</u>	<u>31,667</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>403</u>	<u>540</u>	<u>0</u>	<u>943</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,388</u>	<u>11,222</u>	<u>3,000</u>	<u>32,610</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.17%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/01/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 09/01/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided 3,000Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning: 10/01/2002

Ending: 09/30/2003

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	220,531	19,718		240,249		240,249		240,249			1
2	Food Purchase		158,981		158,981		158,981		158,981			2
3	Housekeeping	100,672	11,747		112,419		112,419		112,419			3
4	Laundry	39,164	14,775		53,939		53,939		53,939			4
5	Heat and Other Utilities			113,148	113,148		113,148		113,148			5
6	Maintenance	63,511	57,273	29,254	150,038		150,038		150,038			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	423,878	262,494	142,402	828,774		828,774		828,774			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,318,333	118,925	89,707	1,526,965		1,526,965		1,526,965			10
10a	Therapy		96,612	305,697	402,309	(103,904)	298,405		298,405			10a
11	Activities	57,168	4,835		62,003		62,003		62,003			11
12	Social Services	23,953	60	2,508	26,521		26,521		26,521			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,399,454	220,432	401,512	2,021,398	(103,904)	1,917,494		1,917,494			16
	<b>C. General Administration</b>											
17	Administrative	59,142			59,142		59,142		59,142			17
18	Directors Fees											18
19	Professional Services			239,681	239,681		239,681	(3,785)	235,896			19
20	Dues, Fees, Subscriptions & Promotions			80,115	80,115	(51,465)	28,650	(13,484)	15,166			20
21	Clerical & General Office Expenses	141,360	13,779	18,272	173,411		173,411		173,411			21
22	Employee Benefits & Payroll Taxes			490,529	490,529		490,529		490,529			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			6,049	6,049		6,049	(4,050)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,767	30,767		30,767		30,767			26
27	Other (specify):*			69,671	69,671		69,671	(69,671)				27
28	<b>TOTAL General Administration</b>	200,502	13,779	937,083	1,151,364	(51,465)	1,099,899	(90,990)	1,008,909			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,023,834	496,705	1,480,997	4,001,536	(155,369)	3,846,167	(90,990)	3,755,177			29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number SAINT CLARE HOME

#0044024

Report Period Beginning: 10/01/2002 Ending: 09/30/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			290,446	290,446		290,446		290,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,000	15,000		15,000	(15,000)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,173	3,173		3,173	(1,102)	2,071			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			308,619	308,619		308,619	(16,102)	292,517			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					103,904	103,904		103,904			39
40	Barber and Beauty Shops			22,954	22,954		22,954		22,954			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			22,954	22,954	155,369	178,323		178,323			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,023,834	496,705	1,812,570	4,333,109		4,333,109	(107,092)	4,226,017			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning:

10/01/2002

Ending:

09/30/2003

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,102)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(15,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment	(4,050)	24		19
20	Contributions	(191)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,785)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,480)	27		24
25	Fund Raising, Advertising and Promotional	(13,484)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,092)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (107,092)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

## SAINT CLARE HOME

ID# 0044024

Report Period Beginning: 10/01/2002

Ending: 09/30/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(1,102)	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		0	20
18			18
19			24
20		(191)	27
21			21
22		(3,785)	19
23			23
24		(69,480)	27
25		(13,484)	20
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(88,042)	49

## Summary A

09/30/2003

(to Sch V, col.7)

[illegible]

## Summary B

09/30/2003

09/30/2003

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SAINT CLARE HOME# 0044024

Report Period Beginning:

10/01/2002Ending: 9/30/2003

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	OSF Healthcare	xx		Working Capital							15,000	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 15,000	9	
	B. Non-Facility Related*												
10	Interest Income										(15,000)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (15,000)	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024 Report Period Beginning: 10/01/2002 Ending: 09/30/2003

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME SAINT CLARE HOME COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0044024

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (     ) \_\_\_\_\_ FAX #: (     ) \_\_\_\_\_

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

### B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 224,000	1
2					2
3	TOTALS			\$ 224,000	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98				\$ 2,682,500	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Smoke Detector			1999	1,932						9
10	Call Light System			1999	16,785						10
11	Sewage Ejector Pump			1999	3,800						11
12	Door Alarm System			1999	1,275						12
13	Chapel Renovation			1999	1,760						13
14											14
15	Wallpaper/Paint --Remodel Hallways			2000	45,058						15
16	Heat / Cool Pump--Rooftop A/C			2000	8,790						16
17	Corridor Renovation			2000	19,472						17
18	Cubicle Curtains			2000	4,020						18
19	Flooring -- Hallways			2000	45,048						19
20	Rooftop A/C Units			2000	328,932						20
21	Window Treatments			2000	7,221						21
22	Sign			2000	720						22
23	Chapel Renovation			2000	32,210						23
24	Smoke Detectors			2000	3,300						24
25											25
26	Wallpaper/Paint --Remodel Hallways			2001	8,820						26
27	Door Alarm			2001	12,678						27
28	Auto Door Opener			2001	1,919						28
29	Vinyl Floor Coverings -- North and West Wing Rooms			2001	73,863						29
30	Vinyl Floor Coverings -- North and West Wing Rooms --Labor			2001	3,750						30
31	Rooftop A/C Units			2001	88,341						31
32	Flooring -- Hallways			2001	3,418						32
33											33
34											34
35	Book Depreciation					229,982		229,982		983,466	35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Security Alarm System	2002	\$ 15,826	\$		\$	\$	\$	37
38	Entry Doors	2002	22,435						38
39	Circulating Pump	2002	4,322						39
40	North Corridor Paint	2002	5,643						40
41	Wallpaper	2002	12,945						41
42	Window Treatments	2002	12,508						42
43									43
44	Phone System	2003	13,908						44
45	North Wing Remodel	2003	888						45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,484,087	\$ 229,982		\$ 229,982	\$	\$ 983,466	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,484,087	\$ 229,982		\$ 229,982	\$	\$ 983,466	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,484,087	\$ 229,982		\$ 229,982	\$	\$ 983,466	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 518,578	\$ 60,464	\$ 60,464	\$		\$ 334,711	71
72	Current Year Purchases	10,746						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 529,324	\$ 60,464	\$ 60,464	\$		\$ 334,711	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,237,411	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 290,446	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 290,446	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,318,177	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,071 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$ 134,761
2	Licensed Speech and Language Development Therapist		hrs			20,126				20,126	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs			143,515	3			143,518	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts				96,609			96,609	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):					7,295				7,295	13
14	TOTAL			\$		\$ 305,697	\$ 96,612		\$	402,309	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 658,906	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	567,005		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,072		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,255,983	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	224,000		13
14	Buildings, at Historical Cost	3,484,087		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	529,324		16
17	Accumulated Depreciation (book methods)	(1,318,177)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,092		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,922,326	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,178,309	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 141,129	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,092		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	509		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Escrow			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 351,782	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 351,782	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,826,527	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,178,309	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,920,248	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,920,248	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(93,721)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (93,721)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 3,826,527	24 *

\* This must agree with page 17, line 47.



**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,165,447	1
2	Discounts and Allowances for all Levels	(951,097)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,214,350	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	789,110	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 789,110	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,958	12
13	Barber and Beauty Care	26,214	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	160,042	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,522	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 191,736	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	16,393	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,393	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Management Fees</b>	28,800	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 28,800	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,240,389	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	828,774	31
32	Health Care	2,021,398	32
33	General Administration	1,151,364	33
	<b>B. Capital Expense</b>		
34	Ownership	308,619	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	22,954	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37		1,001	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,334,110	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(93,721)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (93,721)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

Page 20

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning: 10/01/2002

Ending:

09/30/2003

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,904	2,080	\$ 51,210	\$ 24.62	1
2	Assistant Director of Nursing	2,363	2,487	51,535	20.72	2
3	Registered Nurses	6,407	7,225	136,924	18.95	3
4	Licensed Practical Nurses	19,499	21,754	384,154	17.66	4
5	Nurse Aides & Orderlies	56,061	62,970	650,620	10.33	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,712	2,191	43,890	20.03	8
9	Activity Director					9
10	Activity Assistants	5,077	5,940	57,168	9.62	10
11	Social Service Workers	2,242	2,431	23,953	9.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,687	22,104	220,531	9.98	15
16	Dishwashers					16
17	Maintenance Workers	4,110	4,281	63,511	14.84	17
18	Housekeepers	10,969	12,033	100,672	8.37	18
19	Laundry	3,653	4,161	39,164	9.41	19
20	Administrator	2,080	2,080	59,142	28.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,691	11,750	141,360	12.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,455	163,487	\$ 2,023,834 *	\$ 12.38	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		3,600		36
37	Medical Records Consultant		3,011		37
38	Nurse Consultant				38
39	Pharmacist Consultant		600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,508		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,719		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	262	\$ 7,855		50
51	Licensed Practical Nurses	812	20,312		51
52	Nurse Aides	2,584	51,681		52
53	TOTAL (lines 50 - 52)	3,658	\$ 79,848		53

Facility Name &amp; ID Number SAINT CLARE HOME

# 0044024

Report Period Beginning: 10/01/2002

Ending: 09/30/2003

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Carolyn Conover	Admin	0	\$ 59,142	Workers' Compensation Insurance	\$ 36,635		IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	(3,406)		Advertising: Employee Recruitment	4,968	
				FICA Taxes	154,823		Health Care Worker Background Check (Indicate # of checks performed _____)	401	
				Employee Health Insurance	247,946		Central Office Allocation		
				Employee Meals			Promotional Advertising	2,762	
				Illinois Municipal Retirement Fund (IMRF)*			Public Relations	10,722	
				Employee Hepatitis Vaccine	41,852		Dues and Subscriptions	7,598	
				Employee Benefits -	12,679		License and Fees	2,199	
				Employee Benefits - central office					
							Less: Public Relations Expense	(10,722)	
							Non-allowable advertising (	0	)
							Yellow page advertising	(2,762)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,142	TOTAL (agree to Schedule V, line 22, col.8)	\$ 490,529		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,166	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description		Amount
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
									2,132
									52
							Seminar Expense		3,865
							Non Allowable		(4,050)
							Central Office Allocation		
							Entertainment Expense (		)
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$	1,999
C. Professional Services									
Vendor/Payee	Type		Amount						
Heritage Enterprises	Management Fees		\$ 204,691						
OSF Health System	Management Fees		21,924						
OSF Health System	Audit Fees		3,000						
Morehead Assoc	Human Resources		2,989						
OSF Health System	Pastoral Services		3,292						
			0						
Legal Fees (Adjusted to zero)			3,785						
			0						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 239,681						

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number SAINT CLARE HOME

STATE OF ILLINOIS

# 0044024

Report Period Beginning: 10/01/2002

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,465  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,808
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG Peat Marwick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not Complete as of this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

[illegible]